

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WILLIAM N WISHARD MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1001 W 10TH ST INDIANAPOLIS, IN 46202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State hospital complaint.</p> <p>Complaint #: IN00121689 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 06-05-13</p> <p>Facility number: 005023</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>William N Wishard Memorial Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.6-2, Emergency services, and 410 IAC 15-1.6-4, Out patient services, Hospital Licensure Rules.</p> <p>QA: cloughlin 06/13/13</p>	S 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

S7UQ11

If continuation sheet 1 of 1